Applying for retirees, retirees' spouses, and employees' parents is easy!

Instructions for the long form application

1. Please fill in each section of the application carefully, answering each question completely. Be sure to include the employee's name and social security number.
2. In section 2, select one *Daily Maximum Benefit* and one *Lifetime Maximum Benefit*. Next, indicate if you want the *Benefit Account Non-forfeiture Option* and/or the *Automatic Benefit Increase Option*.
3. In section 4, question 1 asks whether you've applied to or received Medicaid. Also known as Medical Assistance in Minnesota, this program is for persons who meet their state's criteria for poverty. It is not the same as Medicare, which is the program for persons over 65 and certain disabled persons.
4. section 4 asks you about any prescription drugs you are taking, even if it is for a health problem not shown elsewhere.
5. Double-check to make sure you've answered every question and have signed and dated your application in both Sections 6 (if applicable) and 7. If your spouse is applying, he or she should complete, sign and date his or her own application.
6. Mail the completed application(s) to:
   CNA Group Long Term Care, PO Box 946760, Maitland, FL 32794-6760. You need not send money now.
7. We may telephone you after we receive your application to make sure we understand the facts you've noted about your health.
8. We will inform you by mail whether you have been accepted. If you are accepted, we will send you a certificate of coverage and an invoice for your premium.

Please read this before you apply

To keep M-Pel long-term care insurance affordable for all participants, there are some circumstances under which we do not offer coverage. To help you decide whether you should apply, please review these questions:

1. During the past 12 months, have you consulted a physician, been diagnosed or received treatment for any of the following conditions?
   a. Cerebral vascular accident or stroke
   b. Alzheimer's Disease, dementia, or change in cognitive functioning
   c. Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis
   d. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
2. Are you currently residing in a nursing home?

If you answer "no" to all of these, you should apply. While coverage is not guaranteed, some medical conditions will not necessarily disqualify you for coverage.

Questions?
Call CNA customer service: 1-888-653-9600

CNA

Continental Casualty Company

CNA

STATE OF MINNESOTA PLAN

Policy Number: 9938 TQ

Long Term Care Insurance

Long Form Application for retirees, retirees' spouses and employees' parents

M-Pel

SECTION 1 – APPLICANT INFORMATION

Full name (first, middle, last)	Date of birth:	❑ Male ❑ Female
Address	Social Security Number	
City	State	Zip
Daytime phone	Evening phone	

SECTION 2 – BENEFIT SELECTIONS

Select ONE daily benefit:

❑ Choice A: $100 daily benefit

❑ Choice B: $150 daily benefit

Select ONE lifetime maximum:

❑ Value plan: 1250 days x daily benefit (3.4 years)

❑ Select plan: 1825 days x daily benefit (5 years)

Select OPTIONAL benefits:

For an additional cost, you may select one or both of the following optional features:

❑ Non-forfeiture benefit account

❑ Automatic benefit increase option

SECTION 3 – ELIGIBILITY

I certify that I am ❑ a retiree or a retiree's spouses ❑ an employee's parent

Retiree's or employee's full name	Employee's Social Security Number

OVER, PLEASE

SECTION 4 – STATEMENT OF INSURABILITY

1. Height _____ ft. _____ in. Weight _____ lbs.	❑Yes ❑No
2. At any time in the last five years have you applied for or received Social Security Disability Benefits or Medicaid?	❑Yes ❑No
3. During the last seven years indicate if you been diagnosed, received medical advice, or been treated by a member of the medical profession for any of the following:	
a. Auto or acquired immune disorder.	❑Yes ❑No
b. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).	❑Yes ❑No
c. Internal Lupus Erythematosus or any other connective tissue disease or disorder.	❑Yes ❑No
d. Alzheimer's Disease, dementia, or change in cognitive functioning.	❑Yes ❑No
e. Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis.	❑Yes ❑No
f. Seizures, epilepsy or any other neurological disease or disorder.	❑Yes ❑No
g. Emphysema, asthma or chronic bronchitis.	❑Yes ❑No
h. Diabetes Mellitus, glucose intolerance, or hyperglycemia.	❑Yes ❑No
i. Internal cancer or melanoma.	❑Yes ❑No
j. Disorder, disease or surgery of the heart or circulatory system.	❑Yes ❑No
k. Cerebral Vascular Accident, stroke or Transient Ischemic Attack.	❑Yes ❑No
l. High blood pressure.	❑Yes ❑No
m. Osteoporosis.	❑Yes ❑No
n. Arthritis, or any other bone, spine, joint or muscular disease, disorder or surgery.	❑Yes ❑No
o. Reproductive, kidney or urinary system disease, disorder or surgery.	❑Yes ❑No
p. Liver, digestive, colon or rectal disease, disorder or surgery.	❑Yes ❑No
q. Alcoholism or substance abuse.	❑Yes ❑No
r. Any mental, emotional or nervous disease or disorder, depression or chemical imbalance.	❑Yes ❑No
4. During the past 12 months have you consulted a physician, been diagnosed or treated for any of the following? If yes, check those which apply: ❑ Dementia ❑ Dizziness ❑ Loss of appetite ❑ Unstable gait ❑ Falling ❑ Deterioration of vision ❑ Disorientation ❑ Fainting ❑ Bladder control	❑Yes ❑No
5. At any time during the past 12 months have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the following daily activities? If yes, check those which apply: ❑ Bathing ❑ Dressing ❑ Toileting ❑ Continence ❑ Eating ❑ Managing medications ❑ Housekeeping ❑ Preparing meals ❑ Mobility	❑Yes ❑No
6. At any time during the past 12 months have you used any of the following medical devices? If yes, check those which apply: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Oxygen equipment ❑ Catheter	❑Yes ❑No
7. Have you been confined in a long-term care facility or received home health care or adult day care services during the past 12 months?	❑Yes ❑No
8. Have you used any tobacco products at any time during the last three years?	❑Yes ❑No
9. During the past five years, have you received any medical advice, treatment or diagnosis for any condition other than those stated in questions 2 through 7?	❑Yes ❑No

10. Are you taking any prescription drugs? If yes, please provide the name and daily dosage below. ❑Yes ❑No

Drug name	Daily dosage	Take for (diagnosis or condition)	Prescribing doctor

11. If you answered "Yes" to any part of questions 3 through 10, provide details below. To provide more details, attach a separate sheet of paper which is signed and dated.

Question number	Diagnosis	Date treatment began	Ongoing OR date or recovery/control	Name of doctor or facility

12. Please list all physicians which you have consulted or been treated by in the past five years. To provide more details, attach a separate sheet of paper which is signed and dated.

Name of doctor	Specialty	Phone number	Address

13. Does someone else hold your power of attorney? If yes, explain why, what type of power of attorney, and if that power of attorney is being actively used at this time. To provide more details, attach a separate sheet of paper which is signed and dated. ❑Yes ❑No

14. Do you currently have long-term care insurance in force or have you recently applied? If yes, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contracts or health maintenance organizations with the insurance applied for with this application. ❑Yes ❑No

Company name	Policy number	Is coverage to be replaced?	When
		❑Yes ❑No	
		❑Yes ❑No	

SECTION 5 – PAYMENT METHOD

Please select one of the following payment options:

1. Monthly Electronic Funds Transfer

I authorize CNA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel to CNA or its designated agent and my financial institution.

If my premium is paid through electronic funds transfer and there are not sufficient funds in my checking or savings account, you will bill me directly.

Please deduct my monthly premium from (check one):

- ❑ Checking account # (Submit a VOIDED check ONLY)
- ❑ Savings account # (Submit a VOIDED deposit slip ONLY)

Financial institution name:		Telephone
Financial institution address		
City	State	Zip

Attach a VOIDED check (checking account) or deposit slip (savings account). WITHOUT a voided check or deposit slip, we cannot process your application.

Signature of applicant/eligible member _____ Date _____

2. Bill me directly: ❑ Quarterly ❑ Semi-Annually ❑ Annually

SECTION 6 – ALTERNATE BILLING DESIGNEE

I understand I have the right to designate at least one person other than myself to receive notice before my coverage terminates for nonpayment of premium. I designate:

First designee name: _____

Home address: _____

City _____ State _____ Zip _____

Second designee name: _____

Home address: _____

City _____ State _____ Zip _____

OR

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive such notice.

Applicant's Signature _____ **Date** ____/____/____

NEXT PAGE,PLEASE

SECTION 7 – AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I understand and agree that the statements in this application are complete and true to the best of my knowledge and belief and that they will form a part of the contract of insurance. I also understand and agree that the insurance for which I am applying, if issued, shall be based on these statements.

Authorization to Obtain Information

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

"Information" received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information concerning me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company) any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to the Company's agents, brokers, service providers, its reinsurers, or any other third party retained by the Company to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company to determine eligibility for insurance. I understand that this Authorization to Obtain Information shall remain valid for two years from the date shown below. I understand that if I do not sign this Authorization, the Company may not accept my application for insurance.

I UNDERSTAND that the Company may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company to use or disclose such information for consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that I may request to receive a copy of this Authorization and I agree that a photographic copy shall be as valid as the original.

I CERTIFY that I have read, or had read to me, the completed application. All statements in this application are representations and not warranties. If this application is accepted, the insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

Caution Notice: If your answers on this application are incorrect or untrue, the Continental Casualty Company may have the right to deny benefits or rescind your coverage, subject to the incontestability provisions in the policy.

Applicant's Signature _____ **Date** ____/____/____

Coverage is not guaranteed and is based on the information provided.